REQUEST FOR LEAVE

(DD 230.44)

NAME: _____ **LOCATION:** _____
(Print or Type) (Div, Bur, Armory, etc.)

PERIOD: **From:** _____ **To:** _____ **No. of Hours:** _____

TYPE: **Vacation** ☐ **Sick** ☐ **Admin** ☐ **Leave without pay** ☐

Military ☐ **Other** ☐ **PB** ☐

(1) See Below
(2) Attach Orders
(3) Explain Below

_____ _____
(Employee Signature) **(Supervisor's Signature)**

_____
Timekeepers Name/Phone Number (Print or Type)

NJDMAVA Form 101 - 30 November 2001

NOTE: ALL APPROVED LEAVE REQUEST FORMS MUST BE FORWARDED TO YOUR HUMAN RESOURCES OFFICE

Medical evidence is required for periods of five (5) or more days of Sick Leave; or for any periods after an aggregate of fifteen (15) days of Sick Leave used in one calendar year.

During this leave, I certify that I was:

☐ **Ill**
☐ **In attendance of an ill member of my immediate family**

Explanations or Remarks: